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	155530	A. BUILDING 00 B. WING	08/22/2014

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SOUTH SHORE HEALTH & REHABILITATION CENTER	353 TYLER ST GARY, IN 46402

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F000000	This visit was for a Recertification and State Licensure Survey. Survey dates: August 18, 19, 20, 21, and 22, 2014. Facility number: 000369 Provider number: 155530 Aim number: 100275190 Survey team: Heather Tuttle, RN,-TC Lara Richards, RN Cynthia Stramel, RN Yolanda Love, RN Census bed type: SNF/NF: 70 Total: 70 Census payor type: Medicare: 10 Medicaid: 58 Other: 2 Total: 70 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on August 28, 2014, by Janelyn Kulik, RN.	F000000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F000157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. Based on record review and interview, the facility failed to ensure the Physician was notified of a significant weight loss	F000157	The facility will ensure that residents, resident's legal representative or interested family member and physician of	09/21/2014

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	and a resident's responsible party was notified of a change in status for 3 of 3 residents reviewed for notification of change. (Residents #37, #79, and #87) Findings include: 1. The record for Resident #79 was reviewed on 8/21/14 at 10:59 a.m. Review of the resident's weekly weight sheet indicated the resident weighed 138 pounds on 4/2/14. On 4/9/14, the resident weighed 128 pounds, a greater than 5% weight loss within the week. There was no documentation in the Nursing or Dietary Progress Notes to indicate the resident's Physician had been notified of the significant weight loss. Interview with the House Supervisor on 8/22/14 at 9:00 a.m., indicated the resident's Physician should have been notified of the weight loss. 2. The record for Resident #87 was reviewed on 8/20/14 at 10:10 a.m. The resident was admitted to the facility on 3/25/14. The resident was admitted to the hospital on 5/21/14 and readmitted to the facility on 6/18/14. The resident's diagnoses included, but were not limited to, infection in blood stream, pneumonia, hypercholesterolemia, right side weakness, stroke, high blood pressure, dysphagia, aphasia, insomnia, and		changes of room, roommate assignment or weight status Residents identified have had a review to determine if any other notifications requirements have not been met No new issues noted A further review of charts from every unit have been reviewed to ensure that no other residents were affected by deficient practice Nurses will notify family members of changes in status and/or condition Nurses will be in-serviced on notification protocol Social Services Director or designee will be responsible for monitoring changes in rooms or roommates. An intra- facility transfer form has been developed and will be monitored by Social Services or designee at least daily to ensure that notification occurs per policy. Dietary Manager will be responsible for monitoring changes in weights Changes in weights will be reviewed during weekly NAR (Nutrition as Risk) and auditing of notification will be conducted at that time to ensure continued compliance. Both Social Services and Dietary Manager will follow up to ensure that notification occurs per Room Transfer Documentation and per weekly weights. DON or designee will monitoring changes to verify notification as well Results of audits and monitoring will be reported to QA for 6 months on a monthly basis until problem is considered resolved Problem	

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	anemia. Interview with the resident's Power of Attorney (POA) on 8/18/14 at 3:21 p.m., indicated nursing staff does not always inform her when her sister's treatments or medications were changed. Review of the Admission Minimum Data Set (MDS) Assessment dated 6/24/14 indicated the resident had a Brief Interview for Mental Status (BIMS) score of 0, indicating she was not alert and oriented. The resident had no behaviors and was totally dependent on staff for her Activities of Daily Living. The resident had a Percutaneous Endoscopic Gastrostomy (PEG) tube as well as an indwelling foley catheter. Review of Physician Orders dated 6/22/14 indicated the resident was started on the antibiotic Augmentin ES 600 milligrams (mg) give 5 cubic centimeters (cc) 1 teaspoon (tsp) twice a day times 7 days for a respiratory infection. Review of the Nursing Progress Notes dated 6/22/14 indicated there was no family notification indicating there had been a change in the resident's medications. Review of Physician Orders dated 7/1/14,		will be considered resolved when audits show no new issues for a period of 3 months.	

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	indicated cleanse coccyx area with wound wash and apply antibiotic ointment and apply hydrocolloid dressing. Review of Nursing Progress Notes dated 7/1/14 indicated there was no family notification regarding the new open area to the resident's coccyx area. Review of Physician Orders dated 7/7/14, indicated iron 325 mg twice a day for low hemoglobin. Review of the Nursing Progress Notes dated 7/7/14 indicated there was no family notification regarding the low hemoglobin or the addition of an iron supplement to the resident's medication regime. Review of the current and undated Notification for Change in Resident Condition or Status policy provided by the Director of Nursing indicated "The facility and/or facility staff shall promptly notify appropriate individuals (i.e., Administrator, DON, Physician, Guardian, HCPOA, ect) of changes in the resident's medical/mental condition and/or status. Except in medical emergencies, notifications will be made within twenty-four (24) hours of a change occurring in the resident's medical/mental			

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	condition or status." Interview with the Director of Nursing on 8/20/14 at 2:30 p.m., indicated nursing staff were to inform the resident and/or their responsible party whenever there was a change in the resident's condition or a need to alter treatment. 3. The record for Resident #37 was reviewed on 8/21/14 at 2:46 p.m. The resident was admitted to the facility on 6/18/14. The resident diagnoses included, but were not limited to, sepsis secondary to pneumonia. He was admitted with a feeding tube and urinary catheter. The Admission Minimum Data Set Assessment dated 6/25/14 indicated the resident was dependant for transferring and bed mobility. The resident was discharged to the hospital on 7/13/14. The resident's weights were as follows: 6/18/14 207.8 pounds 6/25/14 190.4 pounds 7/2/14 178 pounds 7/9/14 174 pounds This resulted in a significant weight loss of 33.8 pounds or 16.2% of his admission weight within 30 days. There was no documentation of the resident being reweighed.			

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	On the weight record, a notation was written the resident received Lasix (a diuretic) 20 milligrams (mg) daily for edema and "could be water wt (weight)". There were no additional Registered Dietitian (RD) notes or recommendations for the remainder of the residents stay. There were no additional Physician orders related to nutrition. There was no documentation the Physician had been notified of the significant weight loss. Interview with the RD and the Dietary Manager (DM) on 8/22/14 at 10:40 a.m. the RD indicated she had not received notification of the significant weight loss. The facility would fax a referral form to her if there were changes so she could address issues between visits. She indicated when she returned to the facility in July she had been notified the resident was not in the facility any longer. Interview with the House Supervisor on 8/22/14 10:00 a.m. indicated the Physician and Dietician should have been notified of the significant weight loss. Review of the current 12/06 facility policy titled "Resident Weight Monitoring" on 8/22/14 at 9:05 a.m., provided by the House Supervisor, indicated "If there is an actual significant			

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	weight change, the resident, family/guardian, physician and dietitian are notified. The date of the notification is documented in the Nursing Progress notes." 3.1-5(a)(2)			
F000225 SS=E	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.			

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	The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on record review and interview, the facility failed to obtain the required pre-screening procedures for all new employees hired by the facility related to criminal history background checks for 4 of 10 employee files reviewed. (CNA #4, Dietary Aide #1, Activity Aide #1, and Housekeeper #1) Findings include: The Employee files were reviewed on 8/22/14 at 11:30 a.m. The following employees were hired and there was no evidence a criminal history background check had been completed prior to or at the time of employment: A. CNA #1 was hired on 8/5/14 and there was no criminal history background check completed. B. Dietary Aide #1 was hired on 8/1/14 and there was no criminal history background check completed. C. Activity Aide #1 was hired on	F000225	The facility will ensure that all employees receive required pre-screening prior to employment Employees identified during survey have had criminal backgrounds processed No issues noted Other files have been reviewed to ensure that practice did not affect others No issues noted Business Office Manager or designee will ensure that all files are complete prior to employees starting work Only employees with complete files will be allowed to proceed with orientation New employee files will be reviewed by QA Team or designee prior to orientation Audits will be reported to QA for 6 months or until problem is considered resolved.	09/21/2014

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	7/25/14 and there was no criminal history background check completed. D. Housekeeper #1 was hired on 6/5/14 and there was no criminal history background check completed. Interview with the Business Office Manager on 8/22/14 at 1:15 p.m., indicated the criminal history checks for the above employees had not been completed. 3.1-28(a)			
F000226 SS=E	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on record review and interview, the facility failed to follow the facility's policy for obtaining the required pre-screening procedures for all new employees hired by the facility related to criminal history background checks for 4 of 10 employee files reviewed. (CNA #4, Dietary Aide #1, Activity Aide #1, and Housekeeper #1) Findings include:	F000226	The facility will ensure that all employees receive required pre-screening prior to employment Employees identified during survey have had criminal backgrounds processed No issues noted Other files have been reviewed to ensure that practice did not affect others No issues noted Business Office Manager or designee will ensure that all files are complete prior to employees starting work Only employees with complete files will be allowed to proceed with	09/21/2014

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	The Employee files were reviewed on 8/22/14 at 11:30 a.m. The following employees were hired and there was no evidence a criminal history background check had been completed prior to or at the time of employment: A. CNA #1 was hired on 8/5/14 and there was no criminal history background check completed. B. Dietary Aide #1 was hired on 8/1/14 and there was no criminal history background check completed. C. Activity Aide #1 was hired on 7/25/14 and there was no criminal history background check completed. D. Housekeeper #1 was hired on 6/5/14 and there was no criminal history background check completed. Review of the current 3/26/09 Employment Records Required policy provided by the Business Office Manager indicated "The health care employer shall retain on file for a period of 5 years records of criminal record requests for all employees. The health care employer shall retain a copy of the disclosure and authorization forms, a copy of the live scan request form, all notifications resulting from the fingerprint based		orientation New employee files will be reviewed by QA Team or designee prior to orientation Audits will be reported to QA for 6 months or until problem is considered resolved.	

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	criminal history records check and waiver, if appropriate, for the duration of the individuals employment. The health care worker employer shall retain a screen print of the background check initiation page, which documents that the employer did conduct an Internet search of the web sites from the links provided through the Health Care Worker Registry." Interview with the Business Office Manager on 8/22/14 at 1:15 p.m., indicated the criminal history checks for the above employees had not been completed. 3.1-28(a)			
F000241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Based on observation, record review, and interview, the facility failed to ensure each resident's dignity was maintained related to not referring to dependent residents who required assistance with eating as "feeders" for 2 of 2 residents reviewed for dignity. (Residents #42 and #62)	F000241	The facility will ensure that each resident's dignity is maintained. The two residents identified during the survey have been monitored with no negative outcome. Other residents have been interviewed to ensure that their dignity has not been compromised. Interviews have revealed no new issues	09/21/2014

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	Findings include: 1. On 8/19/14 at 12:25 p.m. LPN #2 was observed standing outside of the 400 unit dining room. At that time, she indicated "the residents who ate in this dining room could feed themselves, however there were 'feeders' in the room also." 2. On 8/21/14 at 12:43 p.m., Resident #42 was observed in a wheelchair in the 400 unit dining room. At that time, he was waiting for his meal tray to be passed. Continued observation indicated CNA #1 was passing meal trays to the residents on the unit. At that time, the CNA was overheard speaking to the floor nurse, saying "(Resident name) is a feeder, he gets his tray last." Further observation on 8/21/14 at 12:43 p.m., Resident #62 was observed sitting in the 400 unit dining room. At that time, CNA #1 was observed passing trays to the resident's in their rooms as well as the unit dining room. Continued observation indicated CNA #1 was almost through passing trays as she pulled the last one out of the cart, and indicated to the floor nurse who was standing by her, "This is (resident name), she is a feeder." Interview with CNA #1 on 8/21/14 at 2		identified. Staff will be in-serviced on resident dignity with an emphasis on not referring to residents as feeders. Social Services Director will interview residents and/or staff at least weekly to ensure that deficient practice doesn't reoccur. Results of interviews will be reported to the QA Team on a monthly basis until problem is considered resolved. Problem will be considered resolve when there are no new issues identified for 3 months.	

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	p.m., indicated she should not have called the above residents "feeders". She further indicated she was well aware she should not have done that. 3.1-3(t)			
F000246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. Based on observation and interview, the facility failed to ensure 1 of 40 residents observed during Stage 1 of the survey had a call light located next to their bed on the 300 unit. (Resident #8) Findings include: On 8/19/14 at 10:08 a.m., there was no call light available for Resident #8 who resided in bed 1. There was a call light attached to the middle bed and the other hole for the call light, had a long plastic cylinder tube in the hole. Interview with the Maintenance Supervisor at the time, indicated the resident needed a call light. The Maintenance Supervisor indicated the	F000246	Residents will have call lights within reach of their beds. This issue was corrected while survey team was in the facility. All call lights have been checked to ensure proper functioning and availability. Staff will be in-serviced on call light accessibility. DON or designee will make rounds daily to ensure that call lights are within reach of residents. audits will be conducted at least once a shift. Results of rounds will be reported to the QA Team at least monthly for three months or until problem is considered resolved to ensure continued compliance. Problem will be considered resolved after 30 days of 100% compliance.	09/21/2014

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	resident had recently moved to this room due to his previous room being under repair and he should have his own call light. 3.1-3(v)(1)			
F000247 SS=A	483.15(e)(2) RIGHT TO NOTICE BEFORE ROOM/ROOMMATE CHANGE A resident has the right to receive notice before the resident's room or roommate in the facility is changed. Based on record review and interview, the facility failed to ensure the resident and/or the resident's responsible party was notified in advance of a room change for 1 of 2 resident's reviewed for Admission, Transfer, Discharge of the 2 residents who met the criteria for Admission, Transfer, Discharge. (Resident #87) Findings include: Family Interview on 8/18/14 at 3:18 p.m. for Resident #87, indicated her sister had been moved to a different room and she being her sister's Power of Attorney was not notified of the move. The record for Resident #87 was reviewed on 8/20/14 at 10:10 a.m. The resident was admitted to the facility on	F000247	The facility will ensure that residents, resident's legal representative or interested family member and physician of changes of room, roommate assignment. Residents identified have had a review to determine if any other notifications requirements have not been met No new issues noted A further review of charts from every unit have been reviewed to ensure that no other residents were affected by deficient practice Nurses will notify family members of changes in status and/or condition Nurses will be in-serviced on notification protocol Social Services Director or designee will be responsible for monitoring changes in rooms or roommates. An intra- facility transfer form has been developed and will be monitored by Social Services or designee at least daily to ensure that notification	09/21/2014

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	3/25/14 into room 403. The resident was then sent out to the hospital on 5/21/14 and returned to the facility on 6/18/14. At that time, she was readmitted into room 205. Interview with the Admission Coordinator on 8/22/14 at 11:06 a.m., indicated because the resident was out of the facility longer than 15 days, the facility automatically discharged her. She indicated that was the facility's current policy. She further indicated, she usually knows a couple of days in advance when residents were going to return to the facility. She indicated she had not notified the resident's Power of Attorney the resident would be returning to a different room. The Admission Coordinator indicated sometimes the nurses will call the resident's family and let them know what room they are in after they have returned. Review of the current and undated Bed hold policy provided by the Admissions Coordinator indicated "In the case of an absent resident whose cost of care is paid for by a State or Federal program, he/she may reserve the bed for the number of days the facility is reimbursed the per diem costs of that resident's care as if the resident was actually living in the facility. Should the reservation days expire under		occurs per policy. Social Services will follow up to ensure that notification occurs per Room Transfer Documentation. DON or designee will monitoring changes to verify notification as well Results of audits and monitoring will be reported to QA for 6 months on a monthly basis until problem is considered resolved Problem will be considered resolved when audits show no new issues for a period of 3 months.	

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	the State Program, the responsible party shall have the option of retaining the bed at the private rates for the length of time deemed necessary by said parties." Interview with the Admission Coordinator on 8/22/14 at 11:10 a.m., indicated the current Bed Hold policy was outdated, due to the fact there was no State Assistance Program that reimbursed the facility for the number days a resident was in the hospital. She further indicated, there was no other policy to ensure residents and their family members were notified of a room change when they were readmitted back to the facility. 3.1-3(v)(2)			
F000250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Based on observation, record review and interview, the facility failed to ensure medically related social services were provided related to arranging an Oral Surgery follow up appointment for 1 of 3 residents reviewed for Dental Services of the 3 who met the criteria for Dental	F000250	The facility will ensure that follow up appointments are arranged as ordered. Resident identified is in the process of getting a guardian. The responsible party failed and continues to fail to approve resident's surgery. Once guardian is assigned, surgery can proceed. Other appointments	09/21/2014

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	Services. (Resident #7) Findings include: On 8/20/14 at 9:44 a.m., Resident #7 was observed in his room. The resident had multiple missing and carious teeth. The record for Resident #7 was reviewed on 8/20/14 at 9:46 a.m. A Dental progress note dated 6/13/14, indicated the resident's oral hygiene was poor and he had inflamed gingival tissue (gum tissue). An entry in the Nursing progress notes dated 6/16/14, indicated the oral surgeon's office was contacted regarding an appointment for a full mouth extraction. An appointment was made for 7/15/14. Documentation in the Nursing progress notes dated 7/15/14 at 11:15 a.m., indicated the resident returned from the oral surgeon's office without incident. No new orders were given and a consent needed to be signed by the resident's POA (Power Of Attorney) before the next appointment could be scheduled. On 7/17/14, a consent was signed for oral surgery and anesthesia. Consent signed for "extraction of remaining teeth due to chronic dental abscess." On 7/25/14 at 2:00 p.m. documentation		have been reviewed to ensure compliance with other residents. No issues noted. Residents who have guardians, responsible parties who failed to respond to the facility after three attempts will be assigned guardians. Social Services/DON or designees will monitor per 24-hour report to ensure that families are notified per policy. Audits of 24-hour report will occur daily. Results of monitoring will be reported to the QA Team for 3 months or until problem is considered resolved. Problem is considered resolved when no issues are noted for a period of 3 months	

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	in the Nursing progress notes indicated the resident's tooth extraction was scheduled for 7/29/14 at 12:30 p.m. On 7/29/14 at 12:00 p.m., the resident was transported to the hospital for his tooth extraction. Documentation in the Nursing progress notes at 4:00 p.m., indicated the resident returned from the hospital without having any tooth extractions done due to no consent from POA. Social Service made aware. There was no further documentation in the Nursing or Social Service progress notes related to obtaining consent for the resident's tooth extraction. Interview with the Social Service Director on 8/20/14 at 3:15 p.m., indicated there was no follow up with the resident's POA to obtain consent for the teeth extraction after 7/29/14. 3.1-34(a)			
F000278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health			

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	professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. Based on observation, record review and interview, the facility failed to ensure each comprehensive assessment was accurate related to dental, vision, and antipsychotic use for 1 of 3 residents reviewed for Activities of Daily Living of the 6 residents who met the criteria for Activities of Daily Living and for 1 of 3 residents reviewed for nutrition of the 6 residents who met the criteria for nutrition. (Resident #41 & #43) Findings include: 1. The record for Resident #43 was	F000278	The facility will provide dental services for residents as needed. Resident identified during survey has had her dentures scheduled to replaced. Social Director has completed an audit to ensure that other residents have dentures as needed. No new issue noted. During care plan meetings, residents who require dentures will be assessed for dentures or the need for dentures. Social Services or designee will conduct audits at least weekly to ensure that residents who requires have them. Results of audits will be reported to the QA team at least monthly for three months or until problem is	09/21/2014

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	reviewed on 8/21/14 at 10:15 a.m. The resident's diagnoses included but were not limited to morbid obesity, depression, and chronic anxiety. Review of the Quarterly Minimum Data Set (MDS) Assessment dated 5/23/24 indicated the resident was alert and oriented. She had no mood or behavior problems. The resident received an antidepressant for 7 days and antipsychotic medication was coded with a zero, indicating she did not take any during the assessment period. Review of the Medication Administration Records (MAR)s for the months of May, June, July and August, 2014 indicated the resident had received Abilify (an antipsychotic medication) 7.5 milligrams (mg) daily. Interview with the MDS Coordinator on 8/21/14 at 1:56 p.m., indicated she should had coded the Abilify as an antipsychotic medication. 2. On 8/19/14 at 11:00 p.m., Resident #41 was observed seated in her wheelchair in the main dining room. She did not appear to have any teeth, and was not wearing dentures. She was also not wearing eye glasses. On 8/20/14 at 8:29 a.m., Resident #41		considered resolved. Problem will be considered resolved after 2 months of audits with no new issues noted. The facility will provide dental services for residents as needed. Resident identified during survey has had her dentures scheduled to replaced. Social Director has completed an audit to ensure that other residents have dentures as needed. No new issue noted. During care plan meetings, residents who require dentures will be assessed for dentures or the need for dentures. Social Services will conduct audits at least weekly to ensure that residents who requires have them. Results of audits will be reported to the QA team at least monthly for three months or until problem is considered resolved. Problem will be considered resolved after 2 months of audits with no new issues noted. The facility will ensure that residents receive ADL per assessment of resident needs Residents identified during survey have received ADL care per resident assessment and consent. No new issues noted. Other residents have been assessed to ensure care per resident assessment and consent. No new issues noted. Staff will be in-serviced on ADL protocol. Shower sheets have been updated to reflect additional ADL services to be rendered. DON or designee will audit as least	

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	was observed seated in her wheelchair in the main dining room. She was not wearing dentures or eye glasses. On 8/21/14 at 6:10 a.m., Resident #41 was observed propelling herself down the 300 hallway toward the nursing station. She was not wearing dentures or eye glasses. The resident's record was reviewed on 8/20/14 at 8:32 a.m. The resident was originally admitted to the facility on 10/18/07 and readmitted on 3/10/14. The resident's diagnoses included, but were not limited to, intracerebral hemorrhage, hypertension, cocaine abuse, asthma, and convulsions. There was no care plan related to dental status or vision in the resident's record. A Minimum Data Set (MDS) Quarterly Assessment dated 6/13/14, indicated under the oral/dental status sections, the resident had no issues, including being edentulous (having no teeth), or having loosely fitting dentures. Further review of the MDS also indicated the resident had adequate vision, including no use of corrective lenses. Interview with the resident's family member on 8/19/14 at 12:07 p.m.,		weekly to ensure continued compliance. Results of audits will be reported to QA team at least monthly or until problem is considered resolved. problem will be considered resolved after 3 months of audits with no new issues noted. The facility will ensure that medication classification is documented per drug classification Resident identified has had MDS updated to reflect proper classification of medication. Other medications have been reviewed per MDS to ensure proper classification. No new issues noted. Listing of all psychotropics medications have been provided for reference during MDS process. Compared medication to drug reference guild with each MDS per MDS Coordinator. Audit will be conducted by MDS Coordinator or designee twice per week to ensure accuracy. Continuing monitoring of classification of drugs will be on-going and any issues noted will be reported to the QA Team.	

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	indicated the resident had poor vision and was edentulous. The resident was to wear eye glasses and dentures, however, when visiting with the residents in the facility, the resident never has her eye glasses or dentures in place. Interview with Resident #41 on 8/20/14 at 9:15 a.m., indicated she wore eye glasses and dentures. She further indicated the facility staff did not assist her in putting on her eye glasses on that morning and she no longer had dentures. Interview with CNA #2 on 8/20/14 at 12:00 p.m., indicated she assists the resident with feeding and she had not observed the resident with her dentures in place for about a month, she also indicated she had not seen the resident wearing her eye glasses. 3.1-31(d)(3)			
F000282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, record review and interview, the facility failed to ensure Physician Orders or Care Plans were followed as written related to following	F000282	The facility will ensure that dietary orders are followed per physician orders. Resident identified during survey has had super cereal removed from his order because	09/21/2014

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	dietary orders for 1 of 4 residents reviewed for nutrition, and providing prescribed medications for 1 of 1 resident reviewed for dialysis and for 1 of 1 residents reviewed for death. Also for not assessing a permacath per the plan of care for 1 of 5 residents reviewed for unnecessary drugs. (Resident #31, #39, & #86) Findings include: 1. On 8/20/14 at 8:19 a.m., Resident #31's breakfast tray was observed in his room. The tray card indicated he was to have super cereal (a hot cereal amended to provide extra calories). There was no super cereal on his tray, only cornflakes. On 8/21/14 at 8:00 a.m. the resident was in his room eating breakfast. There was no super cereal on his tray, only cornflakes. The resident's record was reviewed on 8/20/14 at 9:10 a.m. The resident was readmitted to the facility on 5/17/11. Resident diagnoses included, but were not limited to, renal failure, diabetes, bilateral below the knee amputation and anemia. The resident received dialysis three times a week due to renal failure. The August 2014 Physician Order		resident refuses cereal. Other tray cards have been review to ensure compliance. No new issues noted. Dietary Manager or designee will monitor tray cards/dietary orders to ensure compliance. Physician orders may be modified to reflect resident choice. Results of monitoring will be reported to the QA Team on a monthly basis for 3 months or until problem is considered resolved. Problem will be considered resolved when 100% compliance is maintained for 2 months. The facility will ensure laboratory tests are completed as ordered. Resident identified during survey is no longer a resident of the facility. Other charts have been reviewed to ensure compliance with facility protocol relevant to lab administration. No new issues noted. Nursing staff will be in-serviced on facility protocol for laboratory administration. DON or designee will conduct weekly audits for lab to ensure compliance. Results of labs will be reported to QA for at 3 months or until problem is considered resolved. Problem will be considered resolved when no new issues are identified for at least 2 months. The facility will ensure that resident receive medications per physician orders Resident on dialysis is receiving medication per physician order. resident #39 is no longer in the facility. Charts have been audited	

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	Statement (POS) indicated the resident's dietary order was no concentrated sweets, double protein every meal, no orange juice, tomatoes, bananas or oranges and super cereal once daily in the morning. The super cereal was initially ordered on 6/13/12. Interview with the House Supervisor on 8/21/14 at 8:10 a.m. indicated the kitchen was supposed to ensure the resident had super cereal on his tray each morning. Continued observation on 8/20/14 at 11:09 a.m., indicated the resident was observed leaving the facility for dialysis. On his way out the door, LPN #1 handed him a paper bag and paperwork. The August 2014 Medication Administration Record and POS indicated the resident was to receive sodium bicarbonate 200 mg three times a day at 8:00 a.m., 12:00 p.m. and 5:00 p.m. The order indicated, "send noon dose of medication with resident on dialysis days". Interview with the LPN on 8/20/14 at 11:20 a.m. indicated the resident did not take any medications with him to dialysis, the bag contained his lunch only. On dialysis days, he would miss the noon dose of medications. After reviewing the		to ensure that other resident are receiving medications per physician orders. No new issues noted. Nursing staff in-serviced on State regulation for controlled substances. Audits will be conducted on new admission and readmission charts for controlled substances to ensure that orders are filled in a timely manner per physician order. Weekly audits of MAR's will be conducted by the DON or designed to ensure compliance continues. Audits of MAR's will be on-going. Results of audits will be reported to the QA Team on a monthly basis to ensure continued compliance. The facility will ensure that nurses assess permacaths per plan of care. Nurse #4 received a teachable moment related to assessment of permacaths. In-service conducted with nurses related to permacath assessment. audits have been conducted to ensure that no other residents are affected by deficient practice. Binders have been created to identify all dialysis access sites. Nurses have been instructed that binders are available to be used and to identify proper sites. Audits of binders will be conducted by DON or designee to ensure continued compliance. Results of audits will be on-going. Results of audits will be reported to QA on a monthly basis to ensure continued compliance.	

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	POS, the LPN indicated the sodium bicarbonate should have been sent to dialysis with him. 2. The record for Resident #39 was reviewed on 8/21/14 at 9:37 a.m. The resident was admitted to the facility on 3/10/14. The resident's diagnoses included, but were not limited to, dementia and post cerebral vascular accident with left sided paralysis. He was admitted with a feeding tube for nutrition and medications. The March 2014 Physician Order Statement indicated the resident was to receive Modafinil (a psychoactive stimulant) 200 milligrams (mg) every day through the feeding tube. On the Medication Administration Record for March 2014, the Modafinil was circled 3/11/14 through 3/18/14, which indicated the medication had not been given. There was no indication why the medication was not given. Interview with the House Supervisor on 8/21/14 at 12:35 p.m. indicated the medication was not given because it was not received from the pharmacy by the facility. She indicated they should have followed up on the missing medication. Telephone interview on 8/21/14 at 1:10			

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	p.m. with a Pharmacy representative indicated the prescription had been faxed to the pharmacy on 3/10/14. The pharmacy was not able to fill it because the phrase "valid at Intouch Pharmacy" was not written on the prescription, a requirement of controlled medication prescriptions. It was faxed back to the facility on 3/10/14, again on 3/14/14 and requested to include the wording. The pharmacy did not receive it back until 3/18/14, and the medication was sent out at that time. 3. On 8/18/14 at 2:23 p.m., Resident # 86 was observed in his room seated in a wheelchair. A white dressing was noted to his right chest wall. The record for Resident #86 was reviewed on 8/20/14 at 2:10 p.m. The resident was admitted to the facility on 3/10/14. His diagnoses included, but were not limited to, end stage renal disease, dialysis, diabetes, and hypertension. Review of the Care Plan dated 6/17/14 indicated interventions including, but not limited to, manage dialysis site at R1 permacath and RN/LPN to assess dialysis access site for signs and symptoms of infection/non-function/potential problems of: redness, swelling, warmth, tenderness, pain, hardness, chills, fever, purulent or			

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	pus-like drainage on the MAR (Medication Administration Record)/TAR (Treatment Administration Record). Review of the TAR dated 8/1/14, indicated a Physician's Order dated 7/14/14, check dressing to permacath (a hemodialysis catheter) to right chest wall every shift. The treatment had been initialed indicating the task had been completed 8/1/14 thru 8/21/14 for all shifts. Interview with LPN #4 on 8/21/14 at 6:34 a.m., indicated she was Resident #86's regular nurse on the night shift. She stated the resident was a dialysis patient with a shunt (a hemodialysis access site) to his left arm which often clotted. She then indicated the resident no longer had a right permacath due to his shunt being declotted during his last hospital stay. At that time, she walked away. Further interview with LPN #4 at 6:37 a.m., indicated she reassessed the resident and noted a permacath to his right chest wall, and further indicated she should have been assessing the site. Interview with the Director of Nursing (DoN) on 8/22/14 at 9:45 a.m., indicated the nursing staff should have been assessing the resident's permacath on all			

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	shifts and only initialing the treatment in the TAR at the completion of the task. 3.1-35(g)(2)			
F000312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Based on observation, record review and interview, the facility failed to ensure each resident who was unable to carry out Activities of Daily Living (ADL's) received assistance with nail grooming and the placement of eye glasses and dentures for 3 of 3 residents reviewed for Activities of Daily Living of the 6 who met the criteria for Activities of Daily Living. (Resident #3, #41, and #86) Findings include: 1. On 8/18/14 at 2:23 p.m., Resident #86 was observed in his room seated in a wheelchair. His fingernails were noted to be long, dirty, and in need of grooming. Interview at the time indicated the resident desired to have his fingernails groomed. On 8/20/14 at 2:00 p.m., Resident #86 was observed being wheeled down the	F000312	The facility will provide dental services for residents as needed. Resident identified during survey has had her dentures scheduled to replaced. Social Director has completed an audit to ensure that other residents have dentures as needed. No new issue noted. During care plan meetings, residents who require dentures will be assessed for dentures or the need for dentures. Social Services or designee will conduct audits at least weekly to ensure that residents who requires have them. Results of audits will be reported to the QA team at least monthly for three months or until problem is considered resolved. Problem will be considered resolved after 2 months of audits with no new issues noted. The facility will ensure that residents receive ADL per assessment of resident needs Residents identified during survey have received ADL care per resident assessment and consent. No	09/21/2014

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	hall toward the main dining room, his fingernails remained long, dirty, and in need of grooming. The record for Resident #86 was reviewed on 8/20/14 at 2:10 p.m. The resident was admitted to the facility on 3/10/14. His diagnoses included, but were not limited to, end stage renal disease, dialysis, diabetes, and hypertension. A Minimum Data Set (MDS) Quarterly Assessment dated 6/19/14 indicated the resident was cognitively intact and he exhibited no rejection of care behaviors. The resident transferred with an extensive assist of one and required an extensive assist of one with personal hygiene. A Care Plan with no created date indicated the resident required extensive to total assist with ADL's due to decreased cognition and mobility. Interventions included, but were not limited to, staff will complete resident's ADL care and meet the resident's needs. Interview with CNA #2 on 8/20/14 at 2:40 p.m., indicated the resident's fingernails were in need of grooming. Interview with QMA #1 on 8/20/14 at		new issues noted. Other residents have been assessed to ensure care per resident assessment and consent. No new issues noted. Staff will be in-serviced on ADL protocol. Shower sheets have been updated to reflect additional ADL services to be rendered. Shower sheets will be monitored by DON or designee to ensure continued compliance. Results of audits will be reported to QA team at least monthly for 6 months or until problem is considered resolved. Problem will be considered resolved after 3 months of audits with no new issues noted.	

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	2:45 p.m., indicated the staff do not document grooming such as nail care and/or hair washing ADL's on the resident's shower sheets or in the ADL book. She then indicated the only documentation of nail care would be completed by the activity staff on the Daily Activity sheet. On 8/20/14 at 2:55 p.m., LPN #7 was observed in the resident's room providing nail care. At the time she indicated the resident's fingernails were in need of grooming. 2. On 8/19/14 at 9:31 a.m., Resident #3 was observed in the main dining room seated at the table. Her fingernails were noted to be long, dirty, and in need of grooming. On 8/21/14 at 7:05 a.m., Resident #3 was observed in the main dining room, her fingernails remained long, dirty, and in need of grooming. The record for Resident #3 was reviewed on 8/21/13 at 11:15 a.m. The resident was admitted to the facility on 1/13/83. Her diagnoses included schizophrenia, mental disorder, and dementia. A Minimum Data Set (MDS) Annual Assessment dated 7/14/14 indicated the			

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	resident she exhibited no rejection of care behaviors. The resident transferred with supervision and required supervision with personal hygiene. A Care Plan with no created date indicated the resident needs supervision and/or assistance daily with personal hygiene and grooming due to impaired cognitive skills. Interventions included, but were not limited to, check to ensure that ADL's have been performed to usual standards, give limited assist as needed. Interview with the resident on 8/21/14 at 9:00 a.m., indicated her fingernails were in need of grooming and she desired to have her fingernails groomed. Review of the Daily Activity sheet dated August 2014 indicated no evidence of documentation the resident had her nails groomed by activities. Interview with CNA #2 on 8/21/14 at 1:00 p.m., indicated she had trimmed the resident's fingernails today and the last time the resident had her fingernails groomed was during the group activity in the main dining room when activity staff provided nail care. She then indicated documentation would be completed by the activity staff on the Daily Activity sheet.			

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	3. On 8/19/14 at 11:00 p.m., Resident #41 was observed seated in her wheelchair in the main dining room. She did not appear to have any teeth, and was not wearing dentures. She was also not wearing eye glasses. On 8/20/14 at 8:29 a.m., Resident #41 was observed seated in her wheelchair in the main dining room. She was not wearing dentures or eye glasses. On 8/21/14 at 6:10 a.m., Resident #41 was observed propelling herself down the 300 hallway toward the Nurse's station. She was not wearing dentures or eye glasses. The resident's record was reviewed on 8/20/14 at 8:32 a.m. The resident was originally admitted to the facility on 10/18/07 and readmitted on 3/10/14. The resident's diagnoses included, but were not limited to, intracerebral hemorrhage, hypertension, cocaine abuse, asthma, and convulsions. A Minimum Data Set (MDS) Quarterly Assessment dated 6/13/14, indicated the resident exhibited no rejection of care behaviors. The resident transferred with an extensive of one assist and was totally dependent with personal hygiene.			

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	A Care Plan with no created date indicated the resident required full assistance with bathing, grooming, and dressing due to cognitive impairment. Interventions included, but were not limited to, encourage hygiene and grooming and assist as needed. There was no care plan related to dental status or vision in the resident's record. Interview with the resident's family member on 8/19/14 at 12:07 p.m., indicated the resident had poor vision and was edentulous. The resident was to wear eye glasses and dentures, however, when visiting with the resident in the facility, the resident never had her eye glasses or dentures in place. Interview with the Social Service Director on 8/20/14 at 8:29 a.m., indicated the resident was being provided dental services, however, she was unsure if she wore dentures. Interview with Resident #41 on 8/20/14 at 9:15 a.m., indicated she wore eye glasses and dentures. She further indicated the facility staff did not assist her in putting on her eye glasses that morning and she no longer had dentures. Interview with QMA #1 on 8/20/14 at			

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	9:20 a.m., indicated the resident did own and wear eye glasses. She also indicated the resident owned and wore upper and lower dentures and she may be wearing them at this time. Room observation at the time indicated the resident had two pair of eye glasses and a lower denture in the back of her drawer in a blue denture cup. At the time the QMA indicated the resident may have her top dentures in place. Observation of the resident at the time further indicated the resident was not wearing her top dentures. Interview with CNA #2 on 8/20/14 at 9:45 a.m., indicated she was regularly scheduled to work on the 300 hall and she often provided care for Resident #41. She indicated when she arrived each morning the resident was already out of bed, dressed, and seated in the main dining room. She also indicated the resident had not requested to wear her glasses nor her dentures. Further interview indicated the night staff had not reported to her the resident's top dentures were missing. In a follow-up interview with CNA #2 on 8/20/14 at 12:00 p.m., indicated she assisted the resident with feeding and had not observed the resident with her dentures in place in about a month.			

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	Interview with LPN #5 on 8/20/14 at 2:00 p.m., indicated the resident's top dentures had not been located. Interview with CNA #3 on 8/21/14 at 6:00 a.m., indicated she had not observed or assisted the resident with her dentures in over a week. Further interview indicated, when she dressed the resident in the mornings she placed her eye glasses on her, however, the resident had a bad habit of taking them off. Interview with the Social Service Director on 8/21/14 at 10:30 a.m., indicated the resident had a dental consult that morning and was measured for a replacement for her top denture plate. 3.1-38(a)(3)(C) 3.1-38)a)(3)(E)			
F000323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation and interview, the facility failed to ensure hot water temperatures were maintained between	F000323	Hot water temperatures will be maintained per requirements. Temperatures were adjusted during survey.	09/21/2014

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	100-120 degrees Fahrenheit on 1 of 4 units throughout the facility. This had the potential to affect the 21 residents who resided on Unit 3. (Unit 3) Findings include: 1. On 8/19/14 at 11:25 a.m., the hot water temperature in Room 305 registered 122 degrees Fahrenheit. Two residents resided in this room. 2. On 8/19/14 at 10:17 a.m., the hot water temperature in Room 306 registered 133.5 degrees Fahrenheit. Three residents resided in this room. On 8/22/14 at 10:30 a.m., the hot water temperature registered 118 degrees Fahrenheit. 3. On 8/19/14 at 10:23 a.m., the hot water temperature in Room 307 registered 127 degrees Fahrenheit. Two residents resided in this room. The hot water temperature registered 118 degrees Fahrenheit on 8/22/14 at 10:33 a.m. 4. On 8/19/14 at 9:43 a.m., the hot water temperature in Room 309 was 133.5 degrees Fahrenheit. Two residents resided in this room.		Temperatures have been monitored throughout the facility to ensure compliance. No issues noted. Maintenance Director or designee will take temperatures at least every shift to ensure continued compliance. Temperature Logs will be audit by Maintenance Director to ensure compliance. Results of audits will be reported the QA team on a monthly basis for 6 months or until problem is considered resolved. Problem is resolved when there are 3 months of audits with no new issues noted. Monitoring of water temperatures will continue on an on-going basis	

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	The hot water temperature registered 118 degrees Fahrenheit on 8/22/14 at 10:35 a.m. 5. On 8/19/14 at 9:37 a.m., the hot water temperature in Room 310 was 131.5 degrees Fahrenheit. Three residents resided in this room. The hot water temperature registered 107 degrees Fahrenheit on 8/22/14 at 10:40 a.m. 6. On 8/19/14 at 10:51 a.m., the hot water temperature in Room 311 registered 133 degrees Fahrenheit. Two residents resided in this room. The hot water temperature registered 118 degrees Fahrenheit on 8/22/14 at 10:42 a.m. During the survey process the residents were on the unit were observed to be alert and oriented. Interview with the Maintenance Supervisor on 8/19/14 at 10:51 a.m., indicated the hot water temperatures were too high and he would have to turn the water heater down. 3.1-19(r)			

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F000325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. Based on observation, record review and interview, the facility failed to ensure acceptable parameters of nutrition were maintained related to monitoring a significant weight loss and ensuring nutritional assessments were completed for 3 of 3 residents reviewed for Nutrition of the 6 residents who met the criteria for Nutrition. (Residents #37, #43, and #79) Findings include: 1. The record for Resident #79 was reviewed on 8/21/14 at 10:59 a.m. The resident's diagnoses included, but were not limited to, anxiety and dementia. A Physician's order dated 2/26/14, indicated the resident was to receive a	F000325	The facility will ensure acceptable parameters of nutrition and significant weight loss and ensure nutritional assessments are completed. Residents identified during survey have been assessed by the Dietician. No new issues noted. Other residents have had charts reviewed to ensure that residents have been assessed by Dietician. No new issues noted. Residents will be reviewed to NAR (Nutrition at Risk) to ensure that residents have been assessed by Dietician. Staff have been in-serviced on the protocol for nutritional assessments. Residents of NAR will be reported to the QA Team for 3 months or until problem is considered resolved. Problem will be considered resolved when no new issues are identified for at least 2 months. The facility will	09/21/2014

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	regular, no concentrated sweet diet. Review of the resident's weekly weight sheet indicated, on 4/2/14 the resident weighed 138 pounds. On 4/9/14, the resident weighed 128 pounds, a loss of ten pounds within a week. The resident's weight loss was greater than 5% within a week, indicating a significant weight loss. On 4/16/14, the resident weighed 125 pounds and on 4/23/14, the resident weighed 122 pounds. Documentation in the Nursing progress notes on 4/8/14 at 8:00 p.m. indicated the resident was encouraged during meal time, appetite poor. On 4/9/14 at 9:30 p.m., the Nursing progress notes indicated the resident ate 50% of dinner after set up help and encouragement. On 4/11/14 at 9:30 p.m., the Nursing progress notes indicated the resident's appetite was poor, she was fed 25% dinner by writer, required continued encouragement. There was no documentation in the Nursing progress notes indicating the resident's Physician and/or the Registered Dietitian (RD) were notified of the weight loss.		provide dental services for residents as needed. Resident identified during survey has had her dentures scheduled to replaced. Social Director has completed an audit to ensure that other residents have dentures as needed. No new issue noted. During care plan meetings, residents who require dentures will be assessed for dentures or the need for dentures. Audits will be conducted at least weekly to ensure that residents who requires have them. Results of audits will be reported to the QA team at least monthly for three months or until problem is considered resolved. Problem will be considered resolved after 2 months of audits with no new issues noted. The facility will ensure that residents receive ADL per assessment of resident needs Residents identified during survey have received ADL care per resident assessment and consent. No new issues noted. Other residents have been assessed to ensure care per resident assessment and consent. No new issues noted. Staff will be in-serviced on ADL protocol. Shower sheets have been updated to reflect additional ADL services to be rendered. Results of audits will be reported to QA team at least monthly or until problem is considered resolved. problem will be considered resolved after 2 months of audits with no new	

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	A Physician's order dated 4/23/14, indicated the resident was to receive Boost diabetic control (a nutritional supplement) 8 ounces three times daily with meals. Document refusals in Nurses' notes. Review of the Dietary progress notes indicated an initial nutritional assessment was completed by the RD on 2/28/14. No recommendations were made at this time. The next documented entry by the RD was dated 5/15/14, the resident's significant weight loss was addressed at this time. Review of the plan of care dated 2/25/14 indicated the resident was at risk for alteration in nutritional status related to having a therapeutic diet. The interventions included, but were not limited to, monitor and record weight per facility policy. Notify the Physician and RD of significant weight loss and assist resident during meals when needed. Interview with the RD on 8/22/14 at 11:35 a.m., indicated that she was not notified of the resident's significant weight loss for the week of 4/2-4/9/14. She also indicated the resident should have had a re-weight taken. 2. On 8/21/14 at 1:30 p.m., Resident #43		issues noted. The facility will ensure that medication classification is documented per drug classification Resident identified has had MDS updated to reflect proper classification of medication. Other medications have been reviewed per MDS to ensure proper classification. No new issues noted. Listing of all psychotropics medications have been provided for reference during MDS process Continuing monitoring of classification of drugs will be on-going and any issues noted will be reported to the QA Team.	

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	was interviewed. At that time, she indicated it had been quite a while since she had met with the Registered Dietitian (RD). The record for Resident #43 was reviewed on 8/21/14 at 10:15 a.m. The resident was admitted to the facility on 10/6/10. The resident's diagnoses included but were not limited to, morbid obesity, depression, obstructive sleep apnea, high blood pressure, congestive heart failure, chronic anxiety disorder, and muscle spasms. Review of the Quarterly Minimum Data Set (MDS) Assessment dated 5/23/24 indicated the resident was alert and oriented with a Brief Interview for Mental Status (BIMS) score of 15. The resident had no mood or behavior problems. The resident does not transfer, or get out of bed for locomotion on and off the unit. The resident needed extensive assist with dressing, and was totally dependent for bed mobility. The resident's documented weight was 360 pounds. Review of the updated 5/29/14 care plan indicated the resident was at risk for altercation in nutritional status. The resident refused to eat most food and she refused to be weighed. The Nursing			

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	approaches were to provide diet as ordered, monitor and record weight, monitor and report labs, double meat at lunch. Review of the current 2014 weight record indicated there was no weight available due to the resident refused to be weighed on a monthly basis. Review of the an Annual Nutrition Assessment dated 11/26/13 and was completed by the Dietary Food Manager indicated the resident's height was 68 inches. Her diagnoses were indicated, however, the diet, body weight range, labs, supplements/snacks, food allergies, food preferences, religious, cultural, and ethnic preferences, and visual impressions were all blank and not completed. The residents caloric figures were also blank and incomplete. The reverse side of the Assessment indicated the resident was seen by the Dietary Food Manager on 3/1/13, 9/3/13 and 11/22/13. Review of the 9/3/14 note indicated "Non compliant to diet, picky, complains of diets, refuse to be weighed. Albumin low, Calcium low, high risk. Will refer to RD." The next documented assessment was not until 11/22/13 and was by the Dietary			

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	Food Manager which indicated the resident was refusing to be weighed and had complaints of the her diet. She was non compliant. The next and last documented note by was again by the Dietary Food Manager which was 5/23/14. He indicated the resident was morbidly obese. The resident's diet, diagnoses, and appetite were addressed. The resident still refused to be weighed, and had chronic complaints about the food and menu choices. Continued review of Nutritional Progress Notes indicated the last RD note for the resident was dated 4/25/12. The RD indicated her weight was 333 pounds. The resident's previous weight was 358 pounds, in which there was a loss noted. The resident was morbidly obese and ate 100% of meals. Her appetite was good. The RD reviewed her medications, and current labs. Educated resident about adhering to meals provided and less ordering from outside of the facility. Added double meat for breakfast to increase and possible decrease further snacking. Review of lab results dated 11/8/13 indicated an albumin level was 3.4, a normal reading. The normal level was			

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	between 3.4-5.2. The resident's Calcium was 8.1, a low reading. the normal level was between 8.5-10.5. The resident's Hemoglobin was 11.7 a low reading. The normal level was between 12-15.3. Review of lab results dated 2/10/14 indicated an albumin level of 3.3, a low reading. A Calcium level of 8.2, another low reading, and a hemoglobin of 11.1, a low reading. The resident's Hematocrit was 34.4, a low reading. The normal level was between 34.7-45. Review of lab results dated 5/9/14 indicated an albumin level of 3.2, a low reading. A Calcium level of 8.1, a low reading. The resident's hemoglobin was 10.7, a low reading and her Hematocrit was 33.4 another low reading. Review of the lab results dated 7/9/14 indicated the resident's hemoglobin was 11.4 a low reading. Review of the resident's medications indicated the resident was not currently taking any iron, multivitamin, or calcium supplements. Review of 4/07 and current Nutritional Assessment policy provided by the Director of Nursing indicated "The Clinical Dietician in conjunction with the			

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	nursing staff and Attending Physician will assess nutritional issues for each resident admitted to the facility. Nutritional assessments will be reviewed quarterly and revised as necessary." Interview with the Dietary Food Manager on 8/21/14 at 3:35 p.m., indicated staff including himself go to the resident's room and ask her what she would like if she does not want the meal or the alternate. He further indicated his assessment was not complete and a RD had not seen the resident since 4/25/12. Interview with the RD on 8/22/14 at 10:40 a.m., indicated she had attempted to see the resident only one time, and the resident refused her visit. She further indicated she had been coming to the facility since the Fall of 2012 and she had not assessed the resident from a nutritional stand point. She indicated she had not documentation of any visits with the resident or her refusal to see her. She indicated she did not assess the resident back in September 2013 when the Dietary Food Manager had referred the resident to her. 3. The record for Resident #37 was reviewed on 8/21/14 at 2:46 p.m. The resident was admitted to the facility on 6/18/14. The resident diagnoses included, but were not limited to, sepsis			

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	secondary to pneumonia. He was admitted with a feeding tube and urinary catheter. The Admission Minimum Data Set Assessment dated 6/25/14 indicated the resident was dependant for transferring and bed mobility. The resident was discharged to the hospital on 7/13/14. The resident's weights were as follows: 6/18/14 207.8 pounds 6/25/14 190.4 pounds 7/2/14 178 pounds 7/9/14 174 pounds This resulted in a significant weight loss of 33.8 pounds or 16.2% of his admission weight within 30 days. There was no documentation of the resident being reweighed. On 6/18/14, a dietary referral was faxed to the Registered Dietician (RD). The form indicated the resident weighed 207.8 pounds, and received Jevity 1.2 through the feeding tube. On 6/20/14, the RD sent the Dietary recommendations. The Jevity 1.2 was changed to Nutren 1.5. The RD recommended 300 cubic centimeters (cc) of water every shift by the way of the feeding tube. The Physician accepted the recommendations, and the orders were			

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	initiated. On the weight record, a notation was written the resident received Lasix (a diuretic) 20 milligrams (mg) daily for edema and "could be water wt (weight)". There were no additional RD notes or recommendations for the remainder of the residents stay. There were no additional Physician orders related to nutrition. There was no documentation the Physician had been notified of the significant weight loss. Interview with the (RD) and the Dietary Manager (DM) on 8/22/14 at 10:40 a.m. the RD indicated she had not received notification of the significant weight loss. The facility would fax a referral form to her if there were changes so she could address issues between visits. She indicated when she returned to facility in July she had been notified the resident was not in the facility any longer. Interview with the House Supervisor on 8/22/14 at 10:00 a.m. indicated the Physician and the Dietician should have been notified of the significant weight loss. Review of the current 12/06 facility policy titled "Resident Weight Monitoring" on 8/22/14 at 9:05 a.m.,			

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	which was provided by the House Supervisor and identified as current, indicated "if the monthly weight shows a significant change (i.e. 5%+/- in 30 days, 7.5% +/- in 90 days or 10% +/- in 180 days) the resident will be reweighed. If there is an actual significant weight change, the resident, family/guardian, physician and dietitian are notified. The date of notification is documented in the Nursing Progress notes. When weekly weights are obtained, they must be reviewed weekly and action must be taken for any significant change." 3.1-46(a)(1)			
F000329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and			

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	documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. Based on record review and interview, the facility failed to ensure each resident was free from unnecessary medication related to no indication for the use of an antibiotic for 1 of 5 residents reviewed for unnecessary medication of the 5 residents who met the criteria for unnecessary medication. (Resident #87) Findings include: 1. The record for Resident #87 was reviewed on 8/20/14 at 10:10 a.m. The resident was admitted to the facility on 3/25/14. The resident was sent to the hospital and admitted on 5/21/14 and returned to the facility on 6/18/14. The resident's diagnoses included, but were not limited to, pneumonia, diabetes, and stroke. Review of the Admission Minimum Data Set (MDS) Assessment dated 6/24/14 indicated the resident was not alert and oriented and was totally dependent on staff for all Activities of Daily Living. Review of Physician Orders dated 6/22/14 indicated the resident was started	F000329	The facility will ensure that residents receive necessary drugs only. The resident identified during survey has had antibiotic discontinued. Other records have been reviewed to ensure compliance. No new issues noted. Nurses will be in-serviced to ensure that residents receive necessary drugs only. Director of Nursing or designee will audit medication orders at least weekly to ensure continued compliance. Results of audits will be reported to the QA Team at least monthly for 3 months or until problem is considered resolved.	09/21/2014

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	on the antibiotic Augmentin ES 600 milligrams (mg) give 5 cubic centimeters (cc) 1 teaspoon (tsp) bid (twice a day) times 7 days for a respiratory infection. Review of the chest x-ray results dated 5/18/14 indicated there were changes noted in the left lower lobe either due to small amount of left sided pleural effusion and/or infiltrate. Further review of the chest x-ray indicated at the bottom of the page it was noted, "Order for Augmentin 500 milligrams for 10 days. URI (Upper Respiratory Infection)." Review of the same chest x-ray results dated 5/18/14 with a fax date of 6/22/14 indicated at the bottom of the page, "Augmentin ES 600/5 cc 1 tsp-ful bid times 7 days." The x-ray results were also initialed by the Physician. Review of Nursing Progress Notes dated 6/22/14 at 2:00 a.m., indicated "Resident resting quietly in bed. Alert and responsive to verbal and tactile stimuli. Skin warm and dry to touch. Respirations unlabored. Oxygen per nasal cannula at three liters continuously. PEG tube patent, flushed with 300 cc of water and is infusing. Tolerating feeding well. No nausea or vomiting noted. Incontinent of bowel and bladder. Peri care rendered. Right arm and hand			

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	swollen. Turned and repositioned every two hours by staff. Foley catheter patent and intact and draining clear yellow urine. Oxygen saturation 97%. No signs or symptoms of hypo/hyperglycemia reaction. Head of bed elevated, bed in upright position and call light within reach. In no acute distress." The next documented entry in Nursing Progress Notes was on 6/22/14 at 7:30 a.m., which indicated "New order for Augmentin ES 600/5 cc one tsp-ful bid times 7 days due to respiratory infection that was seen on the chest x-ray. Left sided pleural effusion and infiltrate." Further review of Nursing Progress Notes from 6/22/14 through 6/28/14 indicated there was no documentation of any signs or symptoms of an upper respiratory infection for the resident. Review of the Medication Administration Record dated 6/22/14 indicated the Augmentin was signed out as given from 6/22-6/28/14. Interview with the Director of Nursing on 8/20/14 at 2:00 p.m., indicated the chest x-ray was an old one from May 2014 and was not current. She further indicated the resident was admitted to the hospital on 5/22/14 and treated for pneumonia back			

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	then. She indicated there was no documentation to support the use of the antibiotic. 3.1-48(a)(4)			
F000371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, record review and interview the facility failed to ensure a sanitary kitchen related to uncovered food and outdated food in the walk in refrigerator. This had to potential to effect 61 of the 70 residents that received meals prepared from the kitchen. Findings include: On 8/18/14 at 9:05 a.m., the kitchen was observed during the initial tour with the Dietary Manager (DM). In the walk in refrigerator there was a box dated 7/21/14 that contained 2 heads of unwrapped cabbage, a large box of opened raisins dated 10/21/13, and 3-48 ounce containers of cream cheese dated 7/30/14.	F000371	The dietary department will ensure that all items in the refrigerator or freezer are covered and dated per protocol. Items identified during survey have been discarded. The dietary manager has checked all items in refrigerator/freezer to ensure compliance. No new issues noted. The Dietary Manager has in-serviced all staff of proper storage of food items. The Dietary Manager or designee will audit the refrigerator/freezer at least daily to ensure continued compliance. The results of the audits will be reported to the QA Team or at least 3 months or until problem is considered resolved. Problem will be considered resolved when no new issues are identified for at least 2 months.	09/21/2014

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	The Dietary Manager indicated the above items should have been covered, were expired and should be thrown away. The policy for Refrigerators and Freezers was received from the DM on 8/21/14 at 3:15 p.m. The policy indicated, "Place any item to be stored in correct size container. Cover all containers". 3.1-21(i)(3)			
F000412 SS=D	483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist. Based on observation, record review and interview, the facility failed to provide dental services for a resident who required denture replacement for 1 of 3 residents reviewed for dental status and services of the 3 residents who met the criteria for dental status and services.	F000412	The facility will provide dental services for residents as needed. Resident identified during survey has had her dentures scheduled to replaced. Social Director has completed an audit to ensure that other residents have dentures as needed. No new issue noted. During care plan meetings,	09/21/2014

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	(Resident #41) Findings include: On 8/19/14 at 11:00 p.m., Resident #41 was observed seated in her wheelchair in the main dining room. She did not appear to have any teeth, and was not wearing dentures. On 8/20/14 at 8:29 a.m., Resident #41 was observed seated in her wheelchair in the main dining room. She was not wearing dentures. On 8/21/14 at 6:10 a.m., Resident #41 was observed propelling herself down the 300 hallway toward the nursing station. She was not wearing dentures. The resident's record was reviewed on 8/20/14 at 8:32 a.m. The resident was originally admitted to the facility on 10/18/07 and readmitted on 3/10/14. The resident's diagnoses included, but were not limited to, intracerebral hemorrhage, hypertension, cocaine abuse, asthma, and convulsions. A Minimum Data Set (MDS) Quarterly Assessment dated 6/13/14, indicated under the oral/dental status sections, the resident had no issues, including being edentulous (having no teeth), or having		residents who require dentures will be assessed for dentures or the need for dentures. Audits will be conducted at least weekly to ensure that residents who requires have them. Results of audits will be reported to the QA team at least monthly for three months or until problem is considered resolved. Problem will be considered resolved after 2 months of audits with no new issues noted.	

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	loosely fitting dentures. There was no care plan related to dental status in the resident's record. Interview with the resident's family member on 8/19/14 at 12:07 p.m., indicated the resident was edentulous (having no teeth). The resident was to wear dentures, however, when visiting with the resident in the facility, the resident never had her dentures in place. Interview with the Social Service Director on 8/20/14 at 8:29 a.m., indicated the resident was being provided dental services, however, she was unsure if the resident wore dentures. Interview with Resident #41 on 8/20/14 at 9:15 a.m., indicated she was to wear dentures, however, she no longer had dentures. Interview with QMA #1 on 8/20/14 at 9:20 a.m., indicated the resident did own and wear upper and lower dentures and she may be wearing them at this time. Room observation at the time indicated the resident had a lower denture in the back of her drawer in a blue denture cup. At the time the QMA indicated the resident may have her top dentures in place. Observation of the resident at the			

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	time, further indicated the resident was not wearing her top dentures. Interview with CNA #2 on 8/20/14 at 9:45 a.m., indicated she was regularly scheduled to work on the 300 hall and she often provided care for Resident #41. She stated when she arrived each morning the resident was already out of bed, dressed, and seated in the main dining room. She also indicated the resident had not requested to wear her dentures. Further interview indicated the night staff had not reported to her that the resident's top dentures were missing. In a follow-up interview with CNA #2 on 8/20/14 at 12:00 p.m., indicated she assisted the resident with feeding and had not observed the resident with her dentures in place in about a month. Interview with LPN #5 on 8/20/14 at 2:00 p.m., indicated the resident's top dentures had not been located. Interview with LPN #4 on 8/21/14 at 5:55 a.m., indicated she had not been notified the resident's top dentures were missing. Interview with CNA #3 on 8/21/14 at 6:00 a.m., indicated she had not observed or assisted the resident with her dentures			

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	in over a week. Interview with the Social Service Director on 8/21/14 at 10:30 a.m., indicated the resident had a dental consult that morning and was measured for a replacement for her top plate. 3.1-24(a)(3)			
F000431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws,			

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	the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation and interview, the facility failed to ensure multi dose containers of nasal spray and multi dose containers of eye drops were dated after opening for 3 of 4 halls. The facility also failed to ensure a medication cart and multi dose vials of insulin were properly secured for 1 of 4 halls. (Halls 200, 300, and 500) Findings include: 1. On 8/20/14 at 8:10 a.m., a tray of multi dose vials of insulin were observed unattended on top of the unlocked medication cart on the 500 hall. Interview at that time, with LPN #1 indicated she left the multi dose vials of insulin unattended and the medication cart unlocked.	F000431	The facility will ensure that multi dose containers are dated and secured per facility protocol. All issues noted during survey were corrected during survey. An audit has been conducted by the pharmacy since the survey and no new issues were noted. The staff has been in-serviced on facility protocol relevant to storage and safekeeping of multi dose containers. DON or designee will conduct audits at least weekly to ensure continued compliance. Results of the audits will be reported to the QA Team for 3 month or until problem is considered resolved. Problem will be considered resolved when there are at least 2 months of audits with no new issues identified.	09/21/2014

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	2. On 8/22/14 at 5:41 a.m., a tray of multi dose vials of insulin were observed unattended on top of the medication cart on the 500 hall. Interview at that time with LPN #8 indicated she did not leave any medications unattended on the top of her cart. She further stated, "It was only insulin." 3. On 8/22/14 at 10:30 a.m., there were two multi dose containers of eye drops/ointments observed with no open dates in the medication cart on the 200 hall. 4. On 8/22/14 at 10:40 a.m., there were two multi dose containers of nasal sprays observed with no open dates in the medication cart on the 300 hall. 5. On 8/22/14 at 11:10 p.m., on cart #2 there was an inhaler observed with no resident identifier in the medication cart on the 500 hall. Interview with LPN #2 at that time, indicated the inhaler would be discarded. 6. On 8/22/14 at 11:10 p.m., on cart #1 there was one multi dose nasal spray container observed with no open date,			

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	and one multi dose eye drop container observed with no open date in the medication cart on the 500 hall. Review of the current Vials and Ampules of Injectable Medications policy provided by the Director of Nursing (DoN) on 8/22/14 at 1:37 p.m., indicated the date opened and the initials of the first person to use the vial were recorded on multi dose vials on the accessory label affixed for that purpose. Interview with the DoN on 8/22/14 at 9:45 a.m., indicated multi dose vials and/or containers should be labeled with the open date and medication carts and insulin vials should be properly secured and/or attended. 3.1-25(j)			
F000441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents			

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	infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on record review and interview, the facility failed to ensure all new employees received either a first and/or a second step tuberculin mantoux test at the time of hire for 5 of 10 employee files reviewed. The facility also failed to change gloves during a treatment for 2 of 3 treatments observed. (CNA #4, CNA #5, RN #1, Dietary Aide #1, and Housekeeper #1) Findings include:	F000441	The facility will ensure that mantoux 1st and 2nd steps are completed prior to hiring. The employees identified have had 1st and 2nd steps administered. All Negative results. Other files have been reviewed to ensure compliance. No new issues noted. The Business Office Manager or designee will review all personnel files prior to hiring to ensure continued compliance. Audit sheets for personnel files has been updated to include Mantoux Steps. business Office designee will monitor audit sheets	09/21/2014

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	1. The employee files were reviewed on 8/22/14 at 11:30 a.m. The following employees were hired with documentation lacking of either a first or second step tuberculin mantoux skin test and/or a physical exam: A. RN #1 was hired on 2/12/14 there was no first or second step tuberculin mantoux skin test completed. B. CNA #4 was hired on 8/5/14 there was no first or second step tuberculin mantoux skin test, or a physical exam completed. C. Dietary Aide #1 was on 8/1/14 there was no first or second step tuberculin mantoux skin test or a physical exam completed. D. CNA #5 was hired on 7/15/14 there was no second step tuberculin mantoux skin test completed. E. Housekeeper #1 was hired on 6/5/14 there was no second step tuberculin mantoux skin test completed. Review of the current 12/06 Tuberculosis Screening-Administration and Interpretation of Tuberculin Skin Tests policy indicated "All employees shall be screened for tuberculosis infection and		to ensure continued compliance. Audits will be reported to QA for 3 months or until problem is considered resolved. Problem is considered resolved when files for 3 months indicate no new issues. Personnel were provided in-service education on the facility infection control policy and hand washing policy DON or designed will conduct weekly audits of hand washing practice throughout the facility and during treatments. Audits will be conducted at least weekly to ensure compliance. Results of audits will be reported to QA for 3 months or until problem is considered resolved. Problem is considered resolved when audits indicate no new issues for a period of 3 months.	

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	disease, using a two-step tuberculin skin test or chest x-ray, prior to beginning employment." Interview with the Business Office Manager on 8/22/14 at 1:00 p.m., indicated the tuberculin mantoux skin testing and/or the physical exams were not completed for the above mentioned employees at the time of hire. 2. On 8/21/14 at 8:37 a.m., LPN #1 was observed preparing to perform a dressing change. LPN #1 walked into the resident's room and washed her hands with soap and water. She first administered the resident's medications by the way of a Percutaneous Endoscopic Gastrostomy (PEG) tube. After administering the medications she removed her gloves, washed her hands with soap and water and donned a clean pair of gloves. She proceeded to remove the resident's old dressing from her PEG tube site, she then cleaned the area with wound wash, patted the area dry and without changing gloves she applied calcium alginate to the site and covered it with a dry gauze dressing. Review of the current Standard Precaution policy provided by the Director of Nursing (DoN) on 8/21/14 at 10:25 a.m., indicated change gloves between task and procedures on the same			

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	resident after contact with material that may contain a high concentration of microorganisms. Interview with the Director of Nursing on 8/21/14 at 9:00 a.m., indicated the nurse should have donned clean gloves during the dressing change. 3.1-14(t)(1) 3.1-18(b)(1)			
F000456 SS=F	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. Based on observation, record review and interview, the facility failed to ensure essential kitchen equipment was kept in safe operating condition related to the milk refrigerator and walk in freezer having temperatures above acceptable parameters. This had the potential to effect 61 of the 70 residents that received meals prepared in the kitchen. Findings include: On 8/18/14 at 9:05 a.m., the kitchen was observed during the initial tour with the	F000456	The facility will ensure that kitchen equipment is kept in safe operating condition. This problem was corrected while surveyors were in the building. other refrigerators have been check to ensure proper temperature. No new issues noted. Dietary staff have been in-serviced on proper temperature protocol. Temperature logs have been updated to include parameters per policy. Dietary Manager/Administrator will be notified if temperatures are not within range for resolution. Results of temperature logs will be reported to the QA Team for at	09/21/2014

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	Dietary Manager (DM). The milk refrigerator's thermometer read 55 degrees. Review of the August 2014 temperature log attached to the side of the refrigerator indicated temperature was 45 degrees that morning. The log indicated at the top that the refrigerator temperatures should be at 41 degrees or below. There was also a heavy dust accumulation on the vent on the front of the refrigerator. The DM indicated the milk refrigerator was in need of servicing. At 9:15 a.m. the walk in freezer inside thermometer read 20 degrees. The DM indicated he did not believe that to be the correct temperature, and he placed a different thermometer in the freezer. A package of hot dogs and chicken were not frozen solid, the DM indicated those items were put in the freezer that morning. A package of ribs was checked and found to be frozen solid. The freezer temperature log was reviewed, the temperature had been recorded as 0 degrees that day. The log indicated at the top that the freezer must be kept at 0 or below. On 8/20/14 at 3:15 p.m., another observation was made with the DM and the Administrator. The milk refrigerator thermometer read 60 degrees. Review of		least 3 months or until problem is considered resolved. Problem will be considered resolved when no new issues noted for at least 2 months.	

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	the temperature log on the outside of the refrigerator indicated it was 60 degrees on August 19 and 20. A container of milk was checked and found to be 50 degrees, a container of yogurt was found to be 60 degrees. The DM indicated the food should be below 41 degrees. The Administrator indicated the food in the refrigerator would be thrown away. At 3:25 p.m. the walk in freezer thermometer read 22 degrees. Another thermometer in the freezer read 20 degrees. A package of chicken was found to not be frozen solid, and popcicles were found to be soft. The Administrator indicated the freezer and refrigerator were not operating properly and were in need of servicing. 3.1-19(bb)			
F000463 SS=D	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. Based on observation and interview, the facility failed to ensure a functioning call system was maintained on 1 of 4 units throughout the facility. This had the potential to affect the 21 residents who resided on Unit 3. (Unit 3)	F000463	The call light systems will function as installed. This problem as resolved while surveyors were in the facility. All halls have been checked to ensure proper function of call lights. No new issues noted. In-service will be	09/21/2014

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	Findings include: 1. On 8/19/14 at 12:03 p.m., the call light in the bathroom of Room 303 was not functioning. One resident resided in this room. Interview with the Maintenance Supervisor at 12:09 p.m., indicated the system was down for maintenance. 2. On 8/19/14 at 11:25 a.m., the call light in the bathroom of Room 305 was not functioning. The call light did not light up outside of the room nor at the Nurses' station. Two residents resided in this room. 3. On 8/19/14 at 10:17 a.m., the call light in the bathroom of Room 306 was not functioning. The call light did not light up outside of the room nor at the Nurses' station. Three residents resided in this room. 4. On 8/19/14 at 9:43 a.m., the call light in the bathroom of Room 309 was not functioning. The call light did not light up outside of the room nor at the Nurses' station. Two residents resided in this room. 3.1-19(u)(2)		conducted with Maintenance Staff on maintaining proper functioning of call light system. Maintenance Director or designee will conduct audits of system at least weekly. Results of audits will be reported to the QA Team at least monthly for 3 months or until problem is considered resolved to ensure continued compliance. Problem will be resolved when for 3 months no new issues are noted.	

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F000465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFOR TABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation and interview, the facility failed to maintain a functional and sanitary environment related to marred walls, doors, stained floor and ceiling tiles, stained privacy curtains, and dried spillage on walls and tube feeding poles on 4 of 4 units throughout the facility. The facility also failed to ensure a sanitary environment was maintained related to an accumulation of dust on refrigerator fans, sprinkler heads and ceiling vents in 1 of 1 kitchens throughout the facility. This had the potential to affect the 70 residents who resided in the facility. (Units 2, 3, 4 and 5. The Main kitchen) Findings include: 1. During the Environmental Tour on 8/22/14 at 10:30 a.m., with the Maintenance Supervisor, the following	F000465	The facility will maintain a functional and sanitary environment. Issues cited during the survey have been corrected. All areas were effected and all areas have been corrected. The facility will audit areas cited at least weekly to ensure continue compliance. Staff will be in-serviced on the need to keep equipment clean. An audit tool has been established to ensure continued compliance with weekly audits. Weekly audits will be conducted by Dietary Manager or designee and by Maintenance Director or designee to ensure continued compliance. Results of audits will be reported to the QA team at least monthly. This will be an ongoing issue with QA audit reporting.	09/21/2014

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	was observed: Unit 2 a. The paint behind the head of the bed in Room 205 was chipped. One resident resided in this room. b. The caulk was peeling away from the bathroom sink in Room 206. The sink was also loose. One resident resided in this room. c. The paint was chipped behind the head of the bed in Room 213. The base of the tube feeding pole was also dusty and dirty. One resident resided in this room. Unit 3 a. The bathroom door in Room 302 was chipped and marred. The caulking around the bathroom sink was cracked and separated from the wall. The toilet was not flushed and there was a urine odor in the room. Two residents resided in this room. b. The walls next to bed 1 in Room 305 were marred. Two residents resided in this room. c. The non-skid strips next to bed 3 in			

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	Room 306 were peeling and in disrepair. There was a urine odor in the room and stained floor tile at the foot of the bed. Three residents resided in this room. d. Yellow stained floor tile were observed next to the toilet in the bathroom of Room 309. Two residents resided in this room. e. The wall below the bathroom sink in Room 310 was rust stained. The bathroom door was also marred. Three residents resided in this room. Unit 4 a. The wood chair railing behind the head of the bed for bed 1 in Room 401 was cracked. The base of the of bathroom door was paint chipped and marred. Two residents resided in this room. b. The bathroom door in Room 403 was chipped and marred. Also the edge of the door to the room was paint chipped and marred. The ceiling tiles located at the foot of bed 2 were stained and there was peeling plastic on the wheelchair arms for the resident who resided in bed 2. Two residents resided in this room. c. The brick wall underneath the floor			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	register in Room 407 was peeling away and rusty. The wall tile in the bathroom was rusty on the lower end and the door frame was marred. Two residents resided in this room. d. The base of the bathroom door in Room 412 was chipped and marred. There was lime build up in the tub and on the tub faucet. Two residents resided in this room. Unit 5 a. The side rail for bed 1 in Room 501 was paint chipped and had dried spillage present. Two residents resided in this room. b. The privacy curtain for bed 1 in Room 502 was dirty. There was also dried urine on the toilet seat in the bathroom. Two residents resided in this room. c. The privacy curtain for bed 2 in Room 504 was stained. Three ceiling tiles were also stained and there was dried spillage on the wall behind the head of the bed. Two residents resided in this room. d. There were rust stains in the bathtub of Room 505. The bathroom door was marred and the window curtains were loose and missing hooks. Two residents			

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	155530	A. BUILDING 00 B. WING	08/22/2014

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	resided in this room. e. There was dried spillage on the wall behind the head of bed 1 in Room 507. The base of the over bed table located next to bed 1 had an accumulation of rust at the base. Two residents resided in this room. f. The wall clock for bed 2 in Room 508 had a section of plastic missing around the edge. The base of the heating/air conditioning unit was paint chipped and rusty. Two residents resided in this room. g. The door and doorframe for Room 509 was chipped and marred. The bathroom door was also paint chipped and marred. There was also chipped paint on the air conditioner cover. Two residents resided in this room. h. The bathroom door of Room 512 was chipped and marred. The inside of the tub was dirty and the commode lift seat was stored inside the tub. Two residents resided in this room. Interview with the Maintenance Supervisor at the time, indicated all of the above were in need of cleaning and/or repair. 2. On 8/18/14 at 9:05 a.m., the kitchen			

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	was observed during the initial tour with the Dietary Manager. There was a heavy accumulation of dust on the ceiling fan, 2 sprinkler heads on the ceiling, the wall clock and a wall vent in the dishwashing area. There was also a heavy accumulation of dust on the refrigerator vent. The Dietary Manager indicated the above items were in need of cleaning. 3.1-19(f)			
F000502 SS=D	483.75(j)(1) ADMINISTRATION The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. Based on record review and interview, the facility failed to ensure laboratory tests were completed as ordered for 1 of 1 residents reviewed for death of the 1 resident who met the criteria for death. (Resident #39) Findings include: The record for Resident #39 was reviewed on 8/21/14 at 9:37 a.m. The resident was admitted to the facility on 3/10/14. The resident's diagnoses included, but were not limited to, dementia and post cerebral vascular	F000502	The facility will ensure laboratory tests are completed as ordered. Resident identified during survey is no longer a resident of the facility. Other charts have been reviewed to ensure compliance with facility protocol relevant to lab administration. No new issues noted. Nursing staff will be in-serviced on facility protocol for laboratory administration. DON or designee will conduct weekly audits for lab to ensure compliance. Results of labs will be reported to QA for at 3 months or until problem is considered resolved. Problem will be considered resolved when no new issues are identified for at	09/21/2014

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	accident with left sided paralysis. There was a Physician order written on 3/15/14 to obtain a urine analysis with culture and sensitivity on 3/17/14. There were no lab results for this test in the resident's record. Interview with the House Supervisor on 8/21/14 at 12:35 p.m., indicated the urine analysis had not been done as ordered. 3.1-49(a)		least 2 months.	
F009999	Each facility shall maintain current and accurate personnel records for all employees. The personnel records for all employees shall include the following: Documentation of orientation to the facility and to the specific job skills. This State rule was not met as evidenced by: Based on record review and interview, the facility failed to provide new employees a job specific orientation at the time of hire for 8 of 10 employee files reviewed. (LPN #5, LPN #6, RN #1, Activity Aide #1, CNA #5, CNA #6, CNA #7, &, CNA #8)	F009999	The facility will ensure that personnel files are complete for protocol. Employees identified during the survey have had their files updated with job specific orientation. Other files have been reviewed to ensure that the facility is compliant. Issues have been corrected as noted. The audit sheet for new employee files has been updated to reflect job specific orientation. In-service has been conducted with the management team and designees to educate on the need for job specific orientation. Audit sheets will be reviewed by the QA team at least monthly or until problem is considered resolved to ensure continued compliance. Problem will be considered	09/21/2014

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	Findings include: 1. The employee files were reviewed on 8/22/14 at 11:30 a.m. The following employee files were lacking documentation of job specific orientation to their jobs: A. RN #1 was hired on 2/12/14 B. CNA #5 was hired on 7/15/14. C. CNA #6 was hired on 7/17/14. D. CNA #7 was hired on 6/26/14 E. CNA #8 was hired on 5/1/14 F. LPN #5 was hired on 4/3/14 G. LPN #6 was hired on 6/25/14 H. Activity Aide #1 was hired on 7/25/14 Interview with the Business Office Manager on 8/22/14 at 2:00 p.m., indicated all the above employees were not given any type of job specific orientation for their jobs. 3.1-14(q)(7)		resolved when audits reflect no new issues noted for at least 2 months.	

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